PATIENT SAFETY

FEEDBACK

Patient Safety Reporting System
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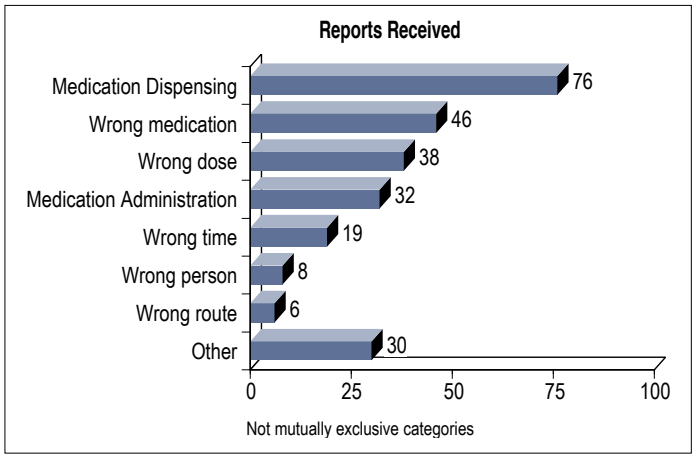
FEEDBACK shares excerpts of reports sent by VA personnel to PSRS. Actual quotes appear in italics. In May 2000, NASA and the VA initiated the PSRS, a voluntary, confidential, and non-punitive reporting system. PSRS encourages VA personnel to describe safety issues from their firsthand experience and to contribute their information to PSRS.

Exercising "The Rights"

Medication issues remain one of the most commonly reported concerns within patient safety. The FDA reports that medication errors lead to at least one fatality each day, injuring up to 1.3 million individuals yearly[1]. This area of patient safety is a high priority area for the VA and for hospitals around the country. PSRS continues to receive reports addressing this important area of safety concern.

To date, of the medication related events reported to PSRS, the most frequently discussed issues include the following:



Right Medication...

PSRS has received another report about look alike/sound alike medications. A recent report described the following:

- *Patient has order for hydralazine that was increased to 25mg on this day. Pharmacy filled and delivered hydroxyzine 25 mg instead… this is the second time this week that this has occurred with the same med and the same patient.*

Right Route...

This alert reporter noted an order that was entered into CPRS with the wrong route and changed it to the correct one:

- *…Physician… was able to order infliximab as an intramuscular injection. This medication is… always administered as an IV infusion over at least two hours…*

[1] *http://www.fda.gov/cder/handbook/mederror.htm*

Right Person...

A reporter wrote to PSRS about a patient receiving someone else's medication:

- *…Patient received* [his] *prescriptions with a different person's prescription in his bag along with his own.*

Right Dose...

A registered nurse reported to PSRS about the wrong dose being given. A patient received a 100 microgram fentanyl patch due to a medication system entry error:

- *…The intended dose was 25 micrograms per hour. The intern who entered the order reported… that the computer would only accept 100 micrograms per order…100 micrograms per order was the default dose.*

After a serious outcome, the reporter states:

- *When I attempted to duplicate the problem 100 micrograms per order was the default dose. I was able to easily change to other doses.*

Right Time

A PSRS reporter described a situation where *short staffing* led to late medication administration. The reporter stated in a PSRS telephone callback that the aide had two days off which were not covered as they had been in the past. The nurse who was processing 300 orders and consults had the lower ratio, but had a total care, total watch patient and 3 admissions. The medications and treatments were not given on time because the initial transcription process had not been done.

PSRS has received many reports about medications expiring in CPRS:

- *Patient was ordered Ritalin… I was on leave for a week. Covering MD receives no notification when an order is due to expire… patient missed 5 doses of Ritalin before I returned…*

Patience with Patients

In 2002, the Department of Health and Human Services (NIOSH) published a report addressing violence in hospitals ("Violence: Occupational Hazards in Hospitals" Publication No. 2002-101). As with the entire healthcare system, the Veterans Health Administration has had to deal with this important issue.

A recent report stated that 13% of VA employees have described at least one assault in the past year (J Occup Environ Med, 2004). A number of published reports addressing violence within the Veterans Health Administration exist (Psychiatr Serv, 2003; Psychiatr Serv, 1999 (2); Hosp Community Psychiatry 1990.) In this portion of *FEEDBACK* we present reports PSRS has received on violence.

A reporter noted the issues related to a call schedule for calling in extra staff when situations warrant it. A patient was admitted who was 'violent to the staff':

- *…The patient in restraints had to be physically restrained in order to obtain lab specimens...the patient was hitting and kicking the staff…*

This resulted in a situation in which nursing staff had to be pulled from other assignments in order to help with the violent patient. This left other patients uncovered.

Reporters have also written about patients with dementia who can become predictably aggressive:

- *…Patient has a history of becoming aggressive when performing personal care. He has no continuous meds to calm him down and a very low dose of his PRN meds.*

The reporter stated this resulted in the need for three people to help, stretching staff thin.

Two other reporters to PSRS remarked on the issue of needing extra staff when patients become violent:

- *While getting patient up for breakfast, he became very combative. Patient has dementia and a history of being combative. Kicking, hitting, and trying to bite staff. He kicked me in the shin real hard leaving a big bruise. After this happened, three other staff members came to help get him up. Due to these patients being unpredictable, I feel like we could use more staff.*

This reporter also told PSRS in a telephone callback that there are 50 similar dementia patients on their locked ward and a total of 6 nursing assistants (2 teams of 3). Reporter stated that some of the ward staff (nursing assistants) are continually on 'light duty' due to patient-related or patient-inflicted injuries.

A second reporter is concerned with the reassignment of a staff member to cover a 1:1 special observation patient, thus resulting in below minimum staff:

- *The new admission was placed on special observation status, this was done as a result of increased agitation, aggressiveness, and hostile behavior. Allowing staff levels to fall below the approved minimum level is a potential risk to patient safety.*

The reporter told PSRS in a telephone callback that this happens at least once a month and patients are aware when it happens. It leads to more aggressive behavior including "banging on walls and doors with furniture and elopement attempts increasing doorway alarms".

PSRS Report Forms are available at VA Facilities and online at:
http://psrs.arc.nasa.gov

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